

FORM **MEPS-11**
(7-7-97)U.S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
ACTING AS COLLECTING AGENT FOR
U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES**MEDICAL EXPENDITURE
PANEL SURVEY
(INSURANCE COMPONENT)
GOVERNMENT QUESTIONNAIRE**

Collection of this information is authorized under Title IX, Section 902(a) of the Public Health Service Act. Sections 903(c) and 308(d) of that Act specify that all information will be held in strict confidence by the staff of the Agency for Health Care Policy and Research and their authorized contractors.

**RETURN
TO****Bureau of the Census
1201 East 10th Street
Jeffersonville, IN 47132-0001**

If you have any questions concerning this survey, please call 1-888-273-3878.

*Please correct errors in name, address, and ZIP Code. ENTER number and street if not shown.***A FEW IMPORTANT INSTRUCTIONS AND DEFINITIONS**

1. For this survey, a **health insurance plan** is defined as providing **hospital and/or physician coverage** for a **single premium** to employees and/or retirees. Exclude extra-cash plans (a specified number of dollars per day in the hospital) or dread-disease (e.g., cancer-only) plans.
2. Coverage could have been purchased from an insurance company, provided by a union or trade association, or self-insured by your governmental unit.
3. **Single and family** plans offered by the same insurance company and providing the same level of hospital and physician benefits count as **one plan**.
4. **High and low** options of a plan offered by the same insurance company count as **two plans**.
5. An **HMO** and a **conventional** plan offered by the same insurance company count as **two plans**.
6. For the deductibles, copayments, and premiums, **report for typical situations and enrollees**. If cost varies by family size, use a **family of four**. If cost varies by age, provide the information for the average age of your workers.
7. **Estimates** are acceptable if you do not have this information readily available.
8. Provide information for the **pay period that included July 1, 1996** for characteristics such as coverage, premiums, and enrollment. Annual totals, such as costs, should be for **calendar year 1996**, if possible, or for the plan year that included July 1, 1996.

Section A - NUMBER OF PLANS**A1.** Did you make available or contribute to the cost of any health insurance plans for your employees or retirees on July 1, 1996? *See instructions 1-5 above for a description of health insurance plans.*001 1 Yes ↗2 No - **If No, go to Section D on page 5.**

003

How many?**Continue with Section B on page 2.**

Section B – PLAN CHARACTERISTICS

B1. On July 1, 1996, what was the name of the health insurance plan with the highest enrollment and its carrier? For additional plans that you offer, use the Supplemental Sheets (if any) or a copy of Section B of this form.

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⁰¹² Name of plan

¹⁰² Name of insurance carrier

B2. Indicate the type of providers in this plan.

- ¹⁰³ 1 **Exclusive providers** – Enrollees must go to providers associated with the plan except in an emergency. There is typically no cost or a small fixed cost for each physician visit. (For example, HMOs, IPAs, EPOs)
- 2 **Any providers** – Enrollees can go to the physicians of their choice on a fee-for-service basis. The plan does not have any associated providers. (For example, conventional plans, indemnity plans)
- 3 **Mixture of preferred and any providers** – Enrollees can go to a set of "preferred" providers associated with the plan, or providers of their choice. If they go to a non-preferred provider, they face higher costs. (For example, PPOs, POSs)

B3. Did this plan **require** that the enrollee see a primary-care physician in order to be referred to a specialist?

- ¹⁰⁴ 1 Yes 2 No

B4. Indicate the type of indemnification of this plan.

- ¹⁰⁵ 1 **Purchased** from an insurance underwriter – Coverage is purchased from an insurance company or other underwriter who assumes the risk for enrollees' medical expenses.

If purchased, go to Question B6.

- 2 **Self-insured** – Your governmental unit pays the claims from its resources and may charge a premium to employees. The plan may be administered by a *third party*. This type may employ supplemental *stop-loss insurance* to limit unanticipated losses.

For self-insured plans only:

B5a. Indicate if you administered the plan or if you employed a third party.

- ¹⁰⁶ 1 Self-administered
2 Insurance company or other administrator

b. Did you purchase stop-loss coverage?

- ¹⁰⁷ 1 Yes 2 No

B5c. Enter this governmental unit's **total annual cost** of coverage for this plan for the plan year that included July 1, 1996. Include: claims paid, administrative costs, and stop-loss coverage (if any). Include employer and employee contributions.

¹⁰⁸ \$.00 *If this is the only plan you offered, also enter this amount in Question C3 on page 4.*

d. Enter the **monthly premium equivalents** (or the COBRA amount if premium equivalents were not calculated) for single and family (of four) coverage for a typical full-time employee. Include the costs entered in B5c. *Also enter this information in Question B10a (single) and B10b (family) – Total premium on page 3.*

¹⁰⁹ \$.00 Single coverage

¹¹⁰ \$.00 Family coverage

e. Is the amount entered in B5d –

- ¹¹¹ 1 A premium equivalent?
2 A COBRA amount?

B6. Was this plan operated by a –

- ¹¹³ 1 Union 2 Trade Association 3 Neither

¹¹⁴ Name of union or trade association

¹¹⁵ Local number, if a union

¹¹⁶ Name of insurance representative

¹¹⁷ Address (*Number and street*)

¹¹⁸ City

¹¹⁹ State

¹²⁰ ZIP Code

¹²¹ Telephone number

()

B7. Did any enrollee receive a direct subsidy or contribution towards any part of the premium (e.g., from a union)?

- ¹²² 1 Yes 2 No

B8. In what month did the plan year begin?

Enter a numeric response (e.g., Jan = 01, May = 05).

¹²³ Month

Section B – PLAN CHARACTERISTICS – Continued

B9a. For this plan, enter the total number of enrollees excluding dependents for this governmental unit on July 1, 1996.

124

b. Enter the total number of active employees enrolled.

125

c. Enter the number of former employees enrolled through COBRA or other State continuation-of-benefits laws.

126

d. Enter the number of retirees enrolled.

127 Total ¹²⁸ 65 and older

e. Enter the **total** number of enrollees with **single** coverage.

129

B10a. Enter this plan's **total** premium, employer contribution, and employee contribution for a typical full-time employee with **single** coverage.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

130 \$.00 Total premium

131 \$.00 Employer contribution

132 \$.00 Employee contribution

Indicate the premium period **Year**

133 1 Week 2 2 weeks 3 Month 4 Year

b. Enter this plan's **total** premium, employer contribution, and employee contribution for an enrolled **family** (of four).

Report for the same premium period as in B10a.

If self-insured, enter the monthly premium equivalent from Question B5d on page 2.

134 \$.00 Total premium

135 \$.00 Employer contribution

136 \$.00 Employee contribution

137 Family coverage was not offered

B11a. Did the **premiums** (not contributions) vary by –
Check all that apply.

- 138 Age?
139 Sex?
140 Number of persons (within family coverage)?
141 Wage or salary levels?
142 Other? – *Specify*

099

B11b. Did the **amount of the employee contribution** (not premium) vary for different employee categories (e.g., full-time, part-time, retiree)?

143 1 Yes 2 No

B12. Did this plan's **premium** include either of these services?
Check all that apply.

144 Life insurance 145 Disability insurance

B13. Enter the **annual deductibles** that enrollees paid out of their pockets before the plan began paying for covered services (using the plan's providers). Many HMO-type plans do not have deductibles.

146 \$.00 **Total individual annual deductible** **OR**

Separate deductibles for:

147 \$.00 Physician care

148 \$.00 Hospital care

If the deductible is per overnight hospital stay, report under B14a.

149 \$.00 **Total family annual deductible** (if applicable)

150 Number of persons – *Enter if the plan also specified that the family deductible was met when a number of family members fulfilled their individual deductibles.*

151 Plan did not have a deductible

B14a. How much did an **enrollee** pay for an **overnight hospital stay** (in a participating hospital, if applicable) after any annual deductible was met?

152 \$.00 → ¹⁵⁴ 1 Per day 2 Per stay

OR

153 Percent **OR**

155 Hospital care was not covered

b. How much did an **enrollee** pay for an **office visit** (with a participating physician, if applicable) after any annual deductible was met?

156 \$.00

OR

157 Percent **OR**

218 Physician care was not covered

B15. What was the maximum amount this plan would have paid for an individual –

a. Over the enrollee's lifetime?

159 \$.00

b. In one year?

160 \$.00

158 No maximum

Section B – PLAN CHARACTERISTICS – Continued

B16. What was the maximum annual out-of-pocket amount for –

a. An individual?

161 \$.00

b. A family (of four)?

162 \$.00

163 No maximum

B17. Indicate which of these services were included in the plan.

Check all that apply.

- 164 Routine mammograms
- 165 Adult routine physical exams
- 166 Routine pap smears
- 167 Office visits for prenatal care
- 168 Adult immunizations
- 169 Child immunizations
- 170 Well-baby care, under 1 year
- 171 Well-child care, 1–4 years
- 172 100% well-baby care
- 173 Chiropractic care
- 174 Other non-physician providers
- 175 Outpatient prescriptions
- 176 Routine dental care
- 177 Orthodontic care
- 178 Nursing home care
- 179 Home health care
- 180 Inpatient mental illness
- 181 Outpatient mental illness
- 182 Alcohol/substance abuse treatment

B18. Could this plan have refused to cover persons with certain preexisting conditions?

183 1 Yes No 2 No

Did this happen in 1996?

184 1 Yes 2 No

B19. Could this plan have imposed a waiting period for persons with certain preexisting conditions?

185 1 Yes 2 No

B20a. Is this plan offered in 1997?

186 1 Yes – **If Yes, go to Question B20c.**
2 No

b. If it is not still offered, indicate if it has been –

- 187 1 Replaced with a similar plan
- 2 Replaced by a substantially different plan
- 3 Dropped without offering a replacement – **Go to Section C.**

c. For 1997, enter the single and family enrollments and premiums for this plan or the one that took its place.

Report for the same premium period as in Question B10a on page 3.

188 Single enrollment

189 Family enrollment

190 \$.00 Single premium

191 \$.00 Family premium

Please complete one Supplemental Sheet for each additional hospital/physician plan you offered your employees and retirees on July 1, 1996. You may use photocopies of the Supplemental Sheet or Section B of this form, if necessary.

Section C – GENERAL HEALTH COVERAGE CHARACTERISTICS

C1a. Did you offer **optional** coverage (not included in the basic health coverage) for any of these services in 1996 at an additional premium to the employee?

Check all that apply.

- 192 Dental
- 193 Vision
- 194 Prescription drugs
- 195 Long-term care

b. What was the total amount paid for these coverages in 1996? *Include employer and employee contributions.*

196 \$.00

C2a. Did you impose a waiting period before new employees could be covered by health insurance?

197 1 Yes No 2 No

b. What was the typical waiting period?

- 198 1 Less than 2 weeks
- 2 2 weeks to less than 1 month
- 3 1–3 months
- 4 More than 3 months

C3. Enter the total annual cost of coverage for the plan year that included July 1, 1996 for **ALL** hospital/physician plans offered by your governmental unit. *Include employer and employee contributions.*

199 \$.00

Section D – EMPLOYMENT CHARACTERISTICS

D1. For the pay period including July 1, 1996, enter the number of employees on your payroll for each of the categories below. Include employees of any dependent agencies associated with your governmental unit. **If you offered health insurance**, also enter the number of employees eligible and enrolled for coverage through your governmental unit and dependent agencies. *Exclude leased or contract workers.*

a. All employees

| | | |
|--------------------------|--------------------------|--------------------------|
| Total | Eligible | Enrolled |
| 200 <input type="text"/> | 201 <input type="text"/> | 202 <input type="text"/> |

b. Part-time employees

| | | |
|--------------------------|--------------------------|--------------------------|
| Total | Eligible | Enrolled |
| 203 <input type="text"/> | 204 <input type="text"/> | 205 <input type="text"/> |

c. Temporary (seasonal) employees

| | | |
|--------------------------|--------------------------|--------------------------|
| Total | Eligible | Enrolled |
| 206 <input type="text"/> | 207 <input type="text"/> | 208 <input type="text"/> |

d. Were retirees eligible to receive health insurance (other than through COBRA or other continuation-of-benefits laws) on July 1, 1996?

219 1 Yes – *Check all that apply* ↗ 2 No

209 Retirees under 65 years

210 Retirees 65 years and over

D2. For the pay period that included July 1, 1996 –

a. Enter the number of women employees 038

b. Enter the number of employees 50 years old or older 039

D2c. Enter the number of employees who were union members 040

d. Enter the number of employees who earned –

042

(1) Less than \$6.50 per hour

043

(2) Between \$6.50 and \$15.00 per hour

044

(3) More than \$15.00 per hour

D3. How many hours per week must an employee work to be considered full time at your governmental unit?

041 Hours

D4. Do you offer any of these fringe benefits?

Check all that apply.

- 050 Paid vacation
- 051 Paid sick leave
- 052 Life insurance
- 053 Disability insurance
- 054 Retirement/pension plans
- 055 Medical Savings Accounts (MSAs)
- 056 Flexible spending accounts
- 057 Cafeteria plan –

Enter the average annual value per employee → 058 \$.00

500 Remarks

Section E – PERSON COMPLETING THIS QUESTIONNAIRE

| | | | |
|-----------------------------|---------------|-----------------------|--------------------|
| 212 Name (Please print) | | 213 Title | |
| Signature | | | 214 Date |
| 215 Telephone number () | 220 Extension | 216 FAX number () | 217 E-Mail address |